

New Year, New Fee Schedule

As most of you are aware, the passing of HB 738 during the 2007 legislative session changed the methodology for reimbursement of medical services provided to injured workers under Montana's workers' compensation law. The result was the Montana Facility Fee Schedule (MFFS), which took effect December 1, 2008, and the Montana Non-Facility Fee Schedule (MNFS), which was implemented on January 1, 2008.

Calculating Reimbursements

The Resource Based Relative Value Scale (RBRVS) publication is used to calculate reimbursement for professional services rendered by licensed health care providers under MNFS. For coding purposes, see the CPT manual that is in effect at the time of the service. Keep in mind that the previous year's RBRVS edition is used for calculation of payment.

For 2008 service dates, use the 2007 edition of the RBRVS with the 2008 CPT manual. For 2009 service dates, the 2008 edition of the RBRVS will be used with the 2009 CPT codes. The RBRVS has the relative value units (RVUs) for each code. The conversion factors for 2008 and 2009 are:

Fee Schedule Type	2008	2009
Standard	\$63.45	\$65.28
Anesthesia	\$57.20	\$61.98

There are two levels of practice expense RVUs that are dependent upon the place of the service code in Box 24B on the CMS 1500 form:

Non-Facility Level: for services performed in a physician's office, patient's home, or other non-facility setting.

Facility Level: for services provided in a hospital, ambulatory surgery center (ASC), skilled nursing facility (SNF) or other licensed medical facility setting. For more information regarding the MNFS, reference the Department of Labor and Industry's (DLI) website at <http://mtwcfeschedule.ingenix.com/overview.aspx>.

Documentation must be submitted with the CMS 1500 form in order to substantiate charges and to establish relationship to injury. All professional services must be billed on a CMS 1500 form.

Montana Facility Fee Schedule

After a short delay, the Montana Facility Fee Schedule (MFFS) was adopted and it now applies to services rendered, and discharge dates, on or after December 1, 2008. It is loosely based on CMS methodology, but governed by Montana Administrative Rules and affects all facilities that provide medical services to injured workers in Montana. The rule also changed the terminology of "hospital" to "facility" to clarify that this fee schedule applies to hospital and ambulatory services.

The fee schedule uses Medicare's MS-DRG (inpatient hospital) and APC (outpatient and ambulatory surgery center) methodology as a basis for reimbursement of services. The MFFS does not incorporate Medicare's rate of reimbursement or allowed procedures and medications. The DLI's website contains the following fee schedule elements:

- Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule
- Montana Hospital Outpatient and ASC Fee Schedule Organized by APC
- Montana Hospital Outpatient and ASC Fee Schedule Organized by CPT/HCPCS
- Montana Ambulance Fee Schedule
- Montana CCI Code Edits Listing
- Montana RCC and other Montana RCC-based Calculations
- Base Rates and Conversion Formulas established by the DLI
- Montana MS-DRG Geometric Table

MS-DRG Methodology: Medicare Severity Diagnosis Related Group

A grouper will need to be used to weight inpatient services; www.hospitalbenchmarks.com is one grouper available at no charge. Reimbursement is calculated by using the base rate multiplied by the Montana MS-DRG weight. See the DLI website for more information regarding calculation of reimbursement for outliers. Services must be billed on a UB04 billing form.

Base Rate: \$7,735.00

Outlier Threshold: three times the Montana MS-DRG payment amount. See the DLI website example for calculating payment when an outlier applies to a bill.

Implant Outlier Threshold: \$10,000.00. Note: When a hospital requests additional payment pursuant to this threshold, the implantable charge is excluded from the calculation for an outlier payment. Reimbursement is set at the actual amount paid plus 15%, and an invoice must be provided to substantiate the charge. It should include the handling and freight. The information provided to MSF regarding invoice costs will be confidential and used only for the purpose of reimbursement.

Implantable: is defined as an object or device that is made to replace and act as a missing biological structure that is surgically implanted, embedded, inserted, or otherwise applied. The term also includes any related equipment necessary to operate, program and recharge the implantable.

Services that Fall Outside of the MS-DRG: and are not otherwise listed on a Montana fee schedule, will be reimbursed at 75% of U&C.

APC Methodology: Ambulatory Payment Classification. Outpatient hospital and ambulatory surgery center services will be calculated according to Medicare's APC weights but at Montana's base rate set by the DLI. The payment is calculated by multiplying the base rate times the APC weight. If the APC weight is not listed or if the APC weight is listed as null, reimbursement must be paid at 75% of U&C. Services must be billed on a CMS 1500 form or UB04 form.

Outpatient Hospital Base Rate: \$105.00

ASC Base Rate: \$79.00

Implant Outlier Threshold: \$500. Reimbursement is set at the actual amount paid plus 15%, and an invoice must be provided to substantiate the charge. It should include the handling and freight. The information provided to MSF regarding invoice costs will be confidential and used only for the purpose of reimbursement.

Durable Medical Equipment Prosthetics, Orthotics and Supplies: will be paid at 75% of U&C charges.

Status Indicators: The DLI has adopted the following status indicators: A, B D, F, G, H, K, L, N, P, S, T and X. Some of the indicators will affect payment. Note: SI "A" includes only ambulance services. DLI did not adopt Medicare's complete definition that includes other services. If there is no APC weight in the Facility Fee Schedule, reimbursement will be at 75% of the U&C charges. See the DLI website for the complete descriptions.

Critical Access Hospitals: will continue to be reimbursed at 100% of the U&C charges.

Inpatient Rehabilitation: including services provided at a long-term inpatient rehabilitation hospital or facility will be paid at 75% of U&C. The services are excluded from the MS-DRG payment system.

Payment of Facility Bills: Facility bills will be paid within 30 days of receipt where there is no dispute over liability. See Administrative Rules of Montana (ARM) rule 24.29.1406 (4) for complete rule.

Documentation Requirements for Facility Bills: When medical bills are submitted electronically, you will no longer need to attach supporting documentation in the majority of cases. Documentation will still be required for implants that hit the outlier threshold and for outpatient services such as physical and occupational therapies, laboratory and radiology services.

For more information regarding the MFFS, reference the Department of Labor's website at <http://erd.dli.mt.gov/wcstudyproject/mffsoverview.asp>.

If you encounter incorrect payments during the transition for the new payment system, please contact a member of the medical team with the bill numbers and we will research and request a correction, if needed.

Professional Services: Medical providers who furnish professional services in a hospital, ASC or other facility setting must bill insurers separately and will be reimbursed using the MNFS. Providers must bill on a CMS 1500 form.

NOTE: DO NOT use the Montana State Fund *Attending Physician's First Report and Initial Treatment Bill* or the *Chiropractor's First Report* for billing or documentation purposes. These forms are no longer used for workers' compensation purposes.

Ambulance Fee Schedule: The Montana Ambulance Fee Schedule is based on data in CMS but it contains ONLY workers' compensation reimbursement rates and calculation for Montana. It includes both ground and air ambulance services. See the DLI website for the complete fee schedule.



Billing Reminders for the New Year

Resolve to get it right the first time.

Durable Medical Equipment

- When submitting corrected billing: please attach a copy of the EOR with any documentation you are submitting. For submission of a corrected bill, please clearly write "Corrected Billing" on the billing form.
- When submitting additional information: attach a copy of the EOR with the additional information.
- Corrected billings and/or additional information should be sent to:

Montana State Fund
PO Box 4759
Helena, MT 59604
Or fax to: 406-444-5963

When submitting refunds for payments received directly from CorVel, please send refunds to Montana State Fund. If payment was received from Montana Health Systems, please send the refund to MHS. Please attach any supporting documentation with your refund.

Exception: If returning a CorVel check that has not been cashed, the check should be returned to:

CorVel Corporation
121 N. Last Chance Gulch
Helena, MT 59601

MT001: Please remember this code is a timed code. The time spent must be documented in the notes or by the signature. Submitting time only on the CMS 1500 is not sufficient for reimbursement. This is a Montana unique code, which replaced CPT code 97799 for purposes of workers' compensation services. It has an RVU of .5 per 15-minute unit. It should only be used for the following services:

- Face-to-face conferences with payor representative(s) to update the status of a patient upon the request of the payor.
- A report associated with non-physician conferences required by the payor.
- Completion of a job description or job analysis. (Signature must be dated.)

Note: Do not use 99080 for the above services to avoid denial of your bill.

Independent Medical Examinations (IME) and Impairment

Ratings (IR): For detailed instructions on billing these services and correct coding, see the Provider Bulletin for Summer 2008, on the Montana State Fund website. Requests for these services originate from a claims examiner or Montana Health Systems, and specify what service is being requested. If uncertain which type of service is being requested, please contact the requestor.

PT, OT, Chiro Reminder: No more than a total of five codes may be billed per visit without prior written authorization. Each 15 minutes of a timed code is equivalent to the billing of one code. Timed codes must have the time clearly documented in the medical record for each code. Each therapy code billed must have part of body treated or clearly identified in the documentation or on the flow sheet. If the notes do not support the procedures billed but refer to a flow sheet, please be sure the flow sheet is attached.

Pre-authorization Required: If providing any durable medical equipment with a purchase price of greater than \$200.00, it must be preauthorized by a claims examiner at Montana State Fund.

- All bills submitted must be on a CMS 1500 or UB04 form with HCPCS code to indicate procedures/supplies and ICD-9 code to indicate the diagnosis.
- MSF has a Preferred Provider Network for DME supplies and services. This network must be used when prescribing DME, O2 equipment and supplies, bone growth stimulators, TENS equipment and supplies, orthotics and prosthetics, and home health services. A list of contracted providers can be found on our website at www.montanastatefund.com.

Radiology Services in a Clinic Setting:

Billing Technical Component (TC): When billing only the technical component (TC) of a radiology service provided in a clinic setting, the service must be billed on a separate CMS 1500 with the clinic listed in Box 31.

Points of Contact:

For questions regarding information in this bulletin, call 800-332-6102 and ask for a member of the medical team.

For questions regarding payment status or an EOR, call CorVel at 406-442-6977 or 866-868-3828.

For questions regarding Advanced Nurse Review, contact any of the following:

Lori Holgate, RN CPC: 406-745-0015

Kym Vonada, LPN, CPC, CPC-H, CPC-P: 800-332-6102 ext. 6134

Debbie Williams, RN, CPC-A: 800-332-6102 ext. 6567



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